FINAL REPORT
OF THE
SELECT JOINT COMMISSION
ON
MEDICAID OVERSIGHT

Indiana Legislative Services Agency
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November, 2004

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Select Joint Commission on Medicaid Oversight

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November 1, 2004

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FINAL REPORT

Select Joint Commission on Medicaid Oversight

I. STATUTORY DIRECTIVE

The Indiana General Assembly enacted the following legislation in H.E.A. 1320-2004 (P.L. 78-2004) directing the Commission to study the issue of continuous eligibility in the Medicaid Program.

SECTION 28. [EFFECTIVE JULY 1, 2004] **(a) In addition to the duties specified under IC 2-5-26, the Select Joint Commission on Medicaid Oversight established by IC 2-5-26-3 shall, to the extent the Commission determines is feasible after consultation with the Office of Medicaid Policy and Planning established by IC 12-8-6-1, study the following effects of the repeal of continuous eligibility for children under the Indiana Medicaid Program and the Children's Health Insurance Program established under IC 12-17.6-2:**

- **(1) Effects on government, including the following:**
  - **(A) Costs to Medicaid and the Division of Family and Children established by IC 12-13-1-1 due to more frequent recertification requirements.**
  - **(B) Loss of revenue from federal matching funds that could not be obtained because of the repeal of continuous eligibility.**
- **(2) Effects on the economy, including the following:**
  - **(A) Indirect cost shifting to providers due to increased charity care because recipients have lapses in eligibility.**
  - **(B) Increased burdens on township assistance (poor relief).**
- **(3) Effects on children, including the following:**
  - **(A) Increases in the level of uninsured children in Indiana.**
  - **(B) Decreases in wellness and the effects on the educational abilities of sicker children.**
- **(4) Effects on families, including the following:**
  - **(A) Effects on family income due to the burden of sicker children.**
  - **(B) Effects on the ability of parents to maintain stable employment due to sicker children or more burdensome recertification procedures.**

(b) The Select Joint Commission on Medicaid Oversight shall submit to the Legislative Council before November 1, 2004, a report of its findings and recommendations concerning the study under subsection (a). The report must be submitted in an electronic format under IC 5-14-6.
(c) This SECTION expires January 1, 2005.

II. INTRODUCTION AND REASONS FOR STUDY

States are permitted to grant continuous Medicaid eligibility for up to 12 months for

children (up to the age of 19) under the federal Balanced Budget Act of 1997. Continuous eligibility is the procedure whereby, once determined to be eligible for Medicaid services, an individual is considered eligible for a predetermined amount of time regardless of changes in the individual's financial and nonfinancial circumstances.

In lieu of continuous eligibility, in Indiana, children are subject to an annual eligibility review unless receiving benefits under the TANF or Food Stamps programs, in which case the child is subject to a six-month review. However, the family is required to report to the Division of Family and Children any change in the child's or family's financial or nonfinancial situation, which may then affect eligibility.

The General Assembly instituted continuous eligibility in 1998 for the Medicaid Program and in 1999 for the Children's Health Insurance Program (CHIP).

Continuous eligibility was established for Medicaid in SECTION 7 of PL 58-1998 (SEA 19-1998).

SECTION 7. IC 12-15-2-15.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 1998]: **Sec. 15.7. (a) An individual who is less than nineteen (19) years of age and who is eligible for Medicaid under sections 14 through 15.6 of this chapter is eligible to receive Medicaid until the earlier of the following:**
(1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.
(2) The individual becomes nineteen (19) years of age.
(b) This section expires August 31, 1999.

Continuous eligibility was established for the CHIP Program in SECTION 22 of PL 273-1999 (HEA 1001).

SECTION 22. IC 12-17.6 IS ADDED TO THE INDIANA CODE AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:
ARTICLE 17.6. CHILDREN'S HEALTH INSURANCE PROGRAM.....
.....
IC 12-17.6-3-3.
Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:
(1) The end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.
(2) The child becomes nineteen (19) years of age.
(b) Subsection (a) applies only if the child and the child's family comply with all enrollment requirements.

The General Assembly subsequently repealed continuous eligibility in PL 107-2002 (SEA 228-2002), in SECTION 25 (for CHIP) and SECTION 32 (for Medicaid).

SECTION 25. IC 12-17.6-3-3, AS ADDED BY P.L.273-1999, SECTION 177, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:
(1) ~~The end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.~~ **The child becomes financially ineligible.**
(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with enrollment requirements.

.....

SECTION 32. IC 12-15-2-15.7 IS REPEALED [EFFECTIVE JULY 1, 2002].

Other States

As of July 2004, 15 state Medicaid programs and 21 state CHIP programs contained continuous eligibility provisions. The status of continuous eligibility provisions for each state is listed in Table 1.

Table 1. Continuous Eligibility Under Medicaid and Separate CHIP Programs, July 2004.[1]

	Medicaid Program	CHIP Program
Alabama	Yes	Yes
Alaska	- -	No separate CHIP program.
Arizona [2]	- -	Yes
Arkansas [3]	- -	No separate CHIP program.
California	Yes	Yes
Colorado	- -	Yes
Connecticut	- -	- -
Delaware	- -	Yes
DC	- -	No separate CHIP program.
Florida [4]	Yes	- -
Georgia	- -	- -
Hawaii	- -	No separate CHIP program.
Idaho	Yes	Yes
Illinois	Yes	Yes
Indiana	- -	- -
Iowa	- -	Yes
Kansas	Yes	Yes
Kentucky	- -	- -

Table 1. Continuous Eligibility Under Medicaid and Separate CHIP Programs, July 2004.[1]		
	Medicaid Program	**CHIP Program**
Louisiana	Yes	No separate CHIP program.
Maine	Yes	Yes
Maryland	- -	- -
Massachusetts	- -	- -
Michigan	Yes	Yes
Minnesota [3]	- -	No separate CHIP program.
Mississippi	Yes	Yes
Missouri	- -	No separate CHIP program.
Montana	- -	Yes
Nebraska	- -	No separate CHIP program.
Nevada	- -	Yes
New Hampshire	- -	- -
New Jersey	- -	- -
New Mexico	- -	No separate CHIP program.
New York	Yes	- -
North Carolina	Yes	Yes
North Dakota [5]	- -	Yes
Ohio	- -	No separate CHIP program.
Oklahoma	- -	No separate CHIP program.
Oregon [6]	- -	- -
Pennsylvania	- -	Yes
Rhode Island	- -	No separate CHIP program.
South Carolina	Yes	No separate CHIP program.
South Dakota	- -	- -
Tennessee [3]	- -	No separate CHIP program.
Texas	- -	- -
Utah	- -	Yes
Vermont	- -	- -
Virginia [7]	- -	Yes
Washington	- -	- -
West Virginia	Yes	Yes
Wisconsin	- -	No separate CHIP program.

Table 1. Continuous Eligibility Under Medicaid and Separate CHIP Programs, July 2004.[1]		
	Medicaid Program	**CHIP Program**
Wyoming	Yes	Yes
United States	15 Medicaid programs, 21 CHIP programs (11 states have for both Medicaid and CHIP programs)	

1. Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to CHIP as well as enhanced CHIP matching payments for these children; CHIP refers to separate CHIP-funded state programs. All 50 states and the District of Columbia have regular Medicaid programs; 36 states have separate CHIP-funded state programs.

2. In Arizona, 12-month continuous eligibility only applies to the first 12 months of coverage in CHIP.

3. In Arkansas, Minnesota and Tennessee, renewal procedures differ for families with children enrolled in Medicaid, depending on whether they are eligible under "regular" Medicaid or under expansions pursuant to Medicaid Section 1115 waivers or CHIP-funded Medicaid expansions. In Arkansas, children who qualify under expansion rules receive 12 months of continuous eligibility, as opposed to a 12-month renewal period in "regular" Medicaid. In Minnesota, children who qualify under the state's waiver program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months. Minnesota plans to implement a 6-month renewal period for its waiver program effective October 1, 2004. In Tennessee, there is an interview requirement in "regular" Medicaid, however it can be done by telephone. The 12-month renewal period in Tennessee is effective October 2004.

4. In Florida, children on Medicaid receive 12 months of continuous eligibility, effective August 12, 2004.

5. In North Dakota, families with children enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

6. In Oregon, the renewal period for pre-expansion Medicaid coverage is 12 months. The renewal period for Medicaid expansion coverage is 6 months.

7. In Virginia, children covered under CHIP get 12 months of continuous coverage unless the family's income exceeds the program's income eligibility guideline or the family leaves the state.

Source: *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Table 7, Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, published by the Henry J. Kaiser Family Foundation, October 2004.

The history of the provision of continuous eligibility in Medicaid and CHIP programs is depicted in the following table, where a high of 18 Medicaid programs and 23 CHIP programs was reached in the January 2002 survey.

Table 2. History of Continuous Eligibility (CE) Under Medicaid and Separate CHIP Programs (No. Of Programs) July 1997 - July 2004.[1]

No. Of Programs As Of	Medicaid	CHIP
July 1997	CE Option Not Available	CE Option Not Available
November 1998	10	Data Not Collected
July 2000	14	22
January 2002	18	23
April 2003	15	21
July 2004	15	21

1. Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to CHIP as well as enhanced CHIP matching payments for these children; CHIP refers to separate CHIP-funded state programs. All 50 states and the District of Columbia have regular Medicaid programs; 36 states have separate CHIP-funded state programs.

Source: *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Table A, Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, published by the Henry J. Kaiser Family Foundation, October 2004.

In testimony provided by Mr. Roos, since January 2002, five states (Connecticut, Nebraska, Indiana, Washington, and New Mexico) have rescinded continuous eligibility, while two states (Florida and Virginia) have added 12-month continuous eligibility for Medicaid. Only Indiana and Texas have eliminated continuous eligibility from their CHIP programs.

III. SUMMARY OF WORK PROGRAM

The Commission met three times in the State House during the 2004 interim.

Meeting #1: June 14, 2004

The Commission received updates on the Medicaid budget, EDS claims processing, the nursing facility assessment issue, the Medicaid spend-down issue, information on Medicaid waivers, and the continuous eligibility issue.

Meeting #2: August 31, 2004

The Commission received an update from EDS, presentations on health disparities, Medicaid managed care, the Chicago Children's Hospital issue, and lead poisoning. The Commission also received testimony on continuous eligibility.

Meeting #3: October 18, 2004

The Commission received testimony on the issue of reimbursement of recreational

therapists, the issue of health disparities and medical interpreters, audits of waiver providers, the Indiana Chronic Disease Management Program, an update on nursing facility assessment, Maine's and Hawaii's pharmaceutical programs, a policy recommendation of the Centers for Medicare and Medicaid Services regarding eligibility of homeless and institutionalized individuals, an update on fraud and audit activities, information on hemophilia, additional testimony on lead poisoning, and additional testimony on continuous eligibility. The Commission also heard an update on the Chicago Children's Hospital situation and heard concerns regarding the reimbursement of inpatient psychiatric services.

The Commission also considered the following proposed legislation: (1) PD 3307 (Medicaid health facility quality assessment), (2) PD 3547 (Medicaid services for foster care individuals), and (3) draft language regarding lead poisoning and children. All three drafts were unanimously approved by the Commission, 7 to 0.

The Commission also approved by unanimous voice vote a recommendation to the Legislative Council that the Select Joint Commission on Medicaid Oversight be exempt from the three-meeting restriction imposed on study committees (Legislative Council Resolution 04-02, SECTION 7(f)).

The draft final report was unanimously approved, with a vote of 7 to 0, assuming the incorporation of testimony and written materials provided to the Commission since the second meeting, and the inclusion of the continuous eligibility recommendations of the Commission.

IV. SUMMARY OF TESTIMONY

This final report primarily involves the subject of continuous eligibility. Testimony on other issues considered by the Commission may be reviewed in the meeting minutes.

On the subject of continuous eligibility, Ms. Melanie Bella, Assistant Secretary for the Office of Medicaid Policy and Planning, provided an overview to the Commission. She stated that continuous eligibility began on September 1, 1998, shortly after Phase I of the CHIP Program began. Children were guaranteed 12 months of Medicaid or CHIP coverage from the date of enrollment, even if income increased or the family did not otherwise meet eligibility requirements after enrollment. Eligibility was then reviewed every 12 months. This policy was ended on July 1, 2002. Currently, families are required to report any changes that might affect eligibility to their caseworker. Children may lose coverage if the reported income exceeds the program limits.

Ms. Bella stated that children in Hoosier Healthwise, which includes both the Medicaid Program and CHIP, must renew coverage at least every 12 months. If enrolled only in Hoosier Healthwise, the child must renew coverage every 12 months, except in the case of income changes. However, for children enrolled in Hoosier Healthwise and also receiving benefits in the Temporary Assistance for Needy Families (TANF) Program or the Food Stamps Program, coverage must be renewed every 6 months according to

their TANF or Food Stamps schedule.

Ms. Bella stated that at the time of the policy change, OMPP estimated that 30,000 Hoosier Healthwise children would be affected by the elimination of continuous eligibility between July 2002 and July 2003. However, she stated that it would be very difficult to estimate the effects after July 2003 due to the difficulty in separating economic and other factors that were also affecting enrollment. She also added that 32,000 more children were enrolled in Hoosier Healthwise today than when continuous eligibility was eliminated.

Ms. Bella also outlined several reasons that children lose coverage:

- The family income is above Medicaid and CHIP limits.
- The family fails to provide income verification or other required information to the caseworker.
- The family fails to return redetermination paperwork or complete renewal interview.
- The child no longer meets eligibility guidelines, such as reaching age 19 or moving out of the state.
- The family voluntarily withdraws from the program because they obtained other insurance.
- The family does not pay monthly premium for Hoosier Healthwise, Package C (CHIP Phase II).
- The caseworker cannot locate the family at time of renewal.

OMPP also provided the following information. For the six months prior to the elimination of continuous eligibility, the average number of net additions to the Hoosier Healthwise caseload was 12,761 children per month. Of those 12,761 children, 3,234 (or 25.3%) had been enrolled in the program sometime in the previous 12 months, while the remaining 9,528 children had not been enrolled in the previous 12 months.

For the 12 months after the elimination of continuous eligibility, the average number of net additions was 14,462 children per month. The number of children who had been enrolled at least one month out of the previous 12, referred to as the “churn rate,” increased to 34.1%. The number of children who had not been enrolled in the previous 12 months remained constant.

Also, during the 6 months prior to the elimination of continuous eligibility, the average monthly change in enrollment was 2,644. This average monthly change in enrollment declined to 335 after the elimination of continuous eligibility.

OMPP added that every year, the enrollment in Hoosier Healthwise continues to increase, and there are more total children enrolled currently than there were prior to the repeal of continuous eligibility. The effect on continuous eligibility has been on the rate of growth.

OMPP made the following additional comments. The number of individuals going to a

county Division of Family and Children office for redetermination after repeal of continuous eligibility may have increased. However, since 58% of the children enrolled in CHIP are also in TANF and Food Stamps, which have a 6-month eligibility redetermination period, the effect of this increase is probably negligible as they would have been going to the county office anyway.

Access to the Hoosier Healthwise program remained constant throughout this period. If a child applied and was eligible for the program, the child received full access to program benefits.

Based on the change in average monthly enrollment, there are approximately 27,600 fewer children per year on Hoosier Healthwise. This amounts to a $13 million reduction in state expenditures per year after elimination of continuous eligibility when using the average per member per month cost for a child.

Mr. David Roos, State Program Director, Covering Kids and Families of Indiana, stated that the federal Balanced Budget Act of 1997 expanded the option available to states to allow children to be eligible for Medicaid or CHIP for a continuous period of 12 months, regardless of intervening changes in family income or family status, and that as part of its larger strategy to "take welfare out of health care" and to promote continuity of care for Indiana's most vulnerable children and families, the General Assembly adopted the policy in 1998. He added that FSSA proposed to eliminate the policy in 2002 in order to reduce Medicaid costs and to "enhance system integrity and program effectiveness." He stated that when continuous eligibility was eliminated, there was an immediate and dramatic reduction in Medicaid enrollment throughout Indiana, and CHIP enrollment for higher income families continued to increase at a faster rate than before. Mr. Roos explained that his organization has been analyzing data from the Indiana Client Eligibility System (ICES) and other information resulting in the following conclusions.

- Eliminating 12-month continuous eligibility has a disproportionate impact upon very low-income families, particularly Medicaid recipients.
- Because of the downturn in the economy, loss of jobs, and the rising cost of health coverage, uninsurance rates in Indiana have steadily increased.
- Despite an overall increase of almost 5% in the total number of children enrolled in Hoosier Healthwise since July 2002, more than 25 Indiana counties still show a total net loss of enrollment due to the elimination of continuous eligibility. Most of the counties that have suffered these losses are small rural counties with high levels of very poor families.
- In Marion, Lake, Allen, St. Joseph, Vanderburgh, Elkhart, and other urban counties, large, very poor inner-city zip codes also have suffered continuing net losses in enrollment despite the continued increase in enrollments for newborns and older children in those same zip codes.
- Hospitals, health centers, and other providers in these counties report dramatically increased rates of disenrollment and subsequent re-enrollment of children ("churning").
- FSSA data indicates that more than 60% of all Hoosier Healthwise case closures for children are for procedural or compliance reasons, rather than actual eligibility

reasons. In Marion County, over 69% of case closures are for procedural reasons.

- Discussions with community-based enrollment centers and Division of Family and Children offices affiliated with Covering Kids and Families indicate increased administrative burdens and reduced "program effectiveness" due to this "churning."
- Independent studies suggest that this "churning" seriously disrupts continuity of care and thereby contributes to ongoing health care disparities among Indiana's most vulnerable families.
- Covering Kids and Families estimates that 50,000 Indiana children have lost health coverage due to the elimination of 12-month continuous eligibility.

Mr. Roos provided data showing the number of unduplicated case closures for children in the Hoosier Healthwise Program between November 2002 and October 2003. The statewide summary of this data is provided in Table 2. Mr. Roos emphasized that the reasons "Failure to Comply" and "Lost - Cannot Locate Family" accounted for approximately 61% of the total case closures.

Reason for Closure	No. Of Cases	% of Total
Income Exceeds Limits	20,807	13.2%
Death	280	0.2%
Failure to Comply	91,177	57.7%
Lost- Cannot Locate Family	4,690	3.0%
Other	8,884	5.6%
Package C - Failure to Pay Premium	4,457	2.8%
Residency	18,823	11.9%
Unknown	2,165	1.4%
Voluntary Withdrawal	6,849	4.3%
Total	158,132	100.0%

Ms. Nancy Swigonski, Division of Children's Health Services Research, Indiana University School of Medicine summarized her research on the impact of eliminating continuous eligibility provisions. Ms. Swigonski's hypothesis was that the more vulnerable populations (i.e., families with lower incomes, those living in rural areas, and minority populations) are least able to negotiate more frequent redeterminations and, therefore, would be disproportionately affected by this policy change.

Using statistical procedures, Ms. Swigonski analyzed the effect on the percentage change in Medicaid and CHIP enrollment from July 2002 to July 2003 by county due to

changes in median household income and percentage population in urban areas while controlling for the percentage of white residents, the percentage of children under 18 years of age living in poverty, and the existence of a Covering Kids and Family's program in the county. Ms. Swigonski concluded that the lowest income groups may be more likely to trigger redeterminations through transient employment, more frequent moves, and the need for other types of public assistance (e.g., TANF and Food Stamps), while also having more barriers to enrollment (such as transportation and literacy). Ms. Swigonski stated that the implications are that eliminating continuous eligibility promotes disparities in health care coverage for the most vulnerable children.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following recommendations regarding continuous eligibility.

(1) The Commission recommends the reinstatement of 12-month continuous eligibility as soon as the state fiscal crisis ends and the budget situation improves. The Commission believes that 12-month continuous eligibility improved retention and continuity of care for Indiana's children.

(2) The Commission also recommends reconvening the Renewal Task Force that was originally created by the Children's Health Policy Board in order to develop specific plans to improve the process of renewing coverage in Medicaid, CHIP, and related programs administered by FSSA. The Renewal Task Force should be charged to help:

(A) Establish baseline case closure and renewal data for all 92 counties prior to January 2005 and agree upon a schedule for reporting comparable trend data back to the Commission.

(B) Develop a process and supporting technology to allow managed care organizations (MCOs), Prime Step primary medical providers (PMPs), and other providers to help FSSA update their enrollee contact information, thereby increasing the opportunity for effective communication about renewal requirements.

©) Develop a process and supporting technology to allow FSSA to share renewal dates and renewal notices with MCOs, Prime Step PMPs, and other providers, thereby increasing the opportunity that recipients will fulfill appropriate renewal requirements.

(D) Review, revise, and reissue existing policies which allow local Division of Family and Children (DFC) offices to work with community-based enrollment centers to assist with the Medicaid and CHIP renewal process, and offer training and support to local DFC offices necessary to successfully implement these policies.

(E) Develop a process and supporting technology to allow FSSA to better utilize shared information from other state information systems to help retain Hoosier Healthwise enrollment rather than merely trigger a "flash bulletin" that may in fact

increase disenrollment due to procedural and compliance reasons.

(F) Develop an educational and marketing campaign to increase enrollee understanding and compliance with appropriate Hoosier Healthwise renewal and information update requirements.

W I T N E S S L I S T

Ms. Melanie Bella, Assistant Secretary for the Office of Medicaid Policy and Planning.
Mr. David Roos, State Program Director, Covering Kids and Families of Indiana.
Ms. Nancy Swigonski, Division of Children's Health Services Research, Indiana University School of Medicine.